

- REPEAL THIS RULE IN ITS ENTIRETY -

Rule R590-165 (Effective 3-16-99)
Health Benefit Plans

R590-165-1. Authority.

This rule is issued pursuant to the general rulemaking authority vested in the commissioner by Section 31A-2-201. Section 31A-22-613.5 requires that the commissioner adopt health benefit plans.

R590-165-2. Scope and Purpose.

A. This rule applies to all insurers marketing health insurance policies of any of the following types:

- (1) traditional major medical coverage;
- (2) preferred provider organization, PPO, coverage; or
- (3) health maintenance organization, HMO, coverage.

B. The commissioner has adopted these three types of health care plans, each with a high and a low option. Insurers marketing these types of health insurance policies within the State of Utah are required to quote and offer for sale to the public, at the request of a potential buyer, each of the plans of the same types that the insurer otherwise markets at both the high and low options of those plans.

C. The purpose of this rule is to set standards for these health benefit plans as required by Section 31A-22-613.5. The three types of plans are designed to facilitate price and value comparisons of health insurance disability policies by consumers. An insurer offering the designated benefit plans may also offer plans that provide more or less coverage than the designated benefit plans.

D. If a company markets none of these three types of plans, they are exempt from this rule.

R590-165-3. Definitions.

A. The following definitions shall be used in each of the adopted health care plans:

(1) "Complications of pregnancy" means an illness, distinct from pregnancy, affecting the mother and occurring during pregnancy and requiring separate and specific medical or surgical services for which separate and additional charges are incurred.

(2) Cost Sharing terms.

(a) For the traditional major medical and PPO plans, the terms applicable to amounts payable by insureds for covered services are deductible, coinsurance, and copayment. These terms are to be defined in PPO and major medical plans, in these words or in words of similar meaning, as follows:

(i) "Deductible" is the amount of covered charges incurred during a specific time period payable by the insured before benefits are provided under the plan.

(ii) "Coinsurance" is the insured's cost-sharing amount expressed as a percentage of covered charges.

(iii) "Copayment" is the insured's cost-sharing amount expressed as a fixed dollar amount payable by the insured each time a specified covered service

is received.

(b) For the HMO plan, the term applicable to amounts payable by insureds for covered services is "copayment." This term is used for both percentage amounts and fixed dollar amounts payable by the insured. The term may be defined in the insurer's HMO plan.

(3) "Custodial care" means:

(a) institutional care, consisting mainly of room and board, which is for the primary purpose of controlling the covered person's environment; and

(b) professional or personal care, consisting mainly of non-skilled nursing services with or without medical supervision, which is for the primary purpose of managing the covered person's disability or

maintaining the covered person's degree of recovery already attained without reasonable expectation of significant further recovery.

(4) "Investigative/experimental technology" means treatment, procedure, facility, equipment, drug, device or supply, "technology", which does not, as determined by the company on a case by case basis, meet all of the following criteria:

(a) The technology must have final approval from all appropriate governmental regulatory bodies, if applicable.

(b) The technology must be available in significant number outside the clinical trial or research setting.

(c) The available research regarding the technology must be substantial. For purposes of this definition, "substantial" means sufficient to allow the company to conclude that:

(i) the technology is both medically necessary and appropriate for the covered person's treatment;

(ii) the technology is safe and efficacious; and

(iii) more likely than not, the technology will be beneficial to the covered person's health.

(d) The technology must be generally recognized as appropriate by the regional medical community as a whole.

R590-165-4. General Requirements.

A. Each insurer may use its own language to present covered services, limitations and exclusions, however, these same services must be covered, limited or excluded by all plans.

B. Each plan must contain a description of the basis for its payments and a statement relative to whether the consumer will be required to pay amounts in excess of the insurer's allowable charges, usual and customary charges, fee schedule amounts, etc.

C. Each insurer's plan must contain a statement relative to whether providers are employed by the insurer or under contract with the insurer and, if so, whether the consumer will be required to pay the full amount or a different amount for services by providers not employed or under contract.

D. Each insurer is to include its usual contracting provisions in its plan: submission of claims, coordination of benefits, eligibility and coverage termination, grievance procedures, general terms and conditions, etc.

E. Each insurer may apply its own "takeover" criteria on group business.

F. If an insurer does not offer an HMO plan, a PPO plan, or a traditional major medical plan, the insurer is not required to offer the designated plan of that type.

If the insurer does not offer coverage to either groups or individuals, the insurer is not required to offer the designated plan or plans for any group or individual, respectively.

G. Samples of these three plans; "Designated Health Benefit Plan Revision Traditional Major Medical Coverage" effective 1-12-99, "Designated Health Benefit Plan Revision to Preferred Provider Organization Coverage" effective 1-12-99, and "Designated Health Benefit Plan Revision to Health Maintenance Organization Coverage" effective 1-12- 99, with their high and low options. These plans are incorporated herein and may be obtained from the Insurance Department. They are to be followed taking into consideration the guidelines of this rule.

H. Forms are to be filed with the department before use.

R590-165-5. Compliance.

A. Insurers within the scope of this rule will be required, at the request of a potential buyer, to quote and offer for sale at least one of the proposed plans, 180 days after the effective date of this rule.

B. Insurers will also be required to adopt any changes made to the plans 180 days after being notified of those changes by the commissioner.

R590-165-6. Severability.

If a provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions may not be affected.

KEY: insurance

1999 (Effective 3-16-99)

31A-2-201
31A-22-613.5

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